

AMENDED IN SENATE APRIL 21, 2014

SENATE BILL

No. 1034

Introduced by Senator Monning

February 14, 2014

An act to amend Sections 1357.51, 1357.514, 1357.600, and 1357.614 of, and to repeal and add Sections 1357.506 and 1357.607 of, the Health and Safety Code, and to amend Sections 10198.7, 10753.05, 10755, and 10755.05 of, and to repeal and add Sections 10753.08 and 10755.08 of, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 1034, as amended, Monning. Health care coverage: waiting periods.

Existing law, the federal Patient Protection and Affordable Care Act (PPACA), enacts various health care coverage market reforms that take effect with respect to plan years on or after January 1, 2014. Among other things, PPACA prohibits a group health plan and a health insurance issuer offering group health insurance coverage from applying a waiting period that exceeds 90 days.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes a group health care service plan contract and a group health insurance policy, as defined, to apply a waiting period of up to 60 days as a condition of employment if applied equally to all eligible employees and dependents.

This bill would prohibit those group contracts and policies from imposing any waiting or affiliation period, as defined, and would make related conforming changes. Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 *SECTION 1. The Legislature hereby finds and declares the*
2 *following:*

3 *(a) In enacting this legislation, it is the intent of the Legislature*
4 *to prohibit a health care service plan or health insurer offering*
5 *group coverage from imposing a separate waiting or affiliation*
6 *period in addition to any waiting period imposed by an employer*
7 *for a group health plan on an otherwise eligible employee or*
8 *dependent.*

9 *(b) The Legislature further intends, in enacting this legislation,*
10 *to permit a health care service plan or health insurer offering*
11 *group coverage to administer a waiting period imposed by a plan*
12 *sponsor, as defined in Section 1002 of Title 29 of the United States*
13 *Code, if consistent with Section 2708 of the federal Public Health*
14 *Service Act (42 U.S.C. Sec. 300gg-7).*

15 ~~SECTION 1.~~

16 *SEC. 2. Section 1357.51 of the Health and Safety Code is*
17 *amended to read:*

18 1357.51. (a) A health benefit plan for group coverage shall
19 not impose any preexisting condition provision or waived
20 condition provision upon any enrollee.

21 (b) (1) A nongrandfathered health benefit plan for individual
22 coverage shall not impose any preexisting condition provision or
23 waived condition provision upon any enrollee.

24 (2) A grandfathered health benefit plan for individual coverage
25 shall not exclude coverage on the basis of a waived condition

provision or preexisting condition provision for a period greater than 12 months following the enrollee's effective date of coverage, nor limit or exclude coverage for a specific enrollee by type of illness, treatment, medical condition, or accident, except for satisfaction of a preexisting condition provision or waived condition provision pursuant to this article. Waivered condition provisions or preexisting condition provisions contained in individual grandfathered health benefit plans may relate only to conditions for which medical advice, diagnosis, care, or treatment, including use of prescription drugs, was recommended or received from a licensed health practitioner during the 12 months immediately preceding the effective date of coverage.

(3) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the Public Health Service Act (42 U.S.C. Sec. 300gg-91), paragraph (1) shall become inoperative 12 months after the date of that repeal or amendment and thereafter paragraph (2) shall apply also to nongrandfathered health benefit plans for individual coverage.

(4) In determining whether a preexisting condition provision or a waived condition provision applies to an individual under this subdivision, a plan shall credit the time the individual was covered under creditable coverage, provided that the individual becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage and applies for coverage under the succeeding plan within the applicable enrollment period.

(c) A health benefit plan for group or individual coverage shall not impose any waiting or affiliation period.

~~(d) In determining whether a preexisting condition provision or a waived condition provision applies to an enrollee, a plan shall credit the time the enrollee was covered under creditable coverage, provided that the enrollee becomes eligible for coverage under the succeeding plan contract within 62 days of termination of prior coverage and applies for coverage under the succeeding plan within the applicable enrollment period. A plan shall also credit any time that an eligible employee must wait before enrolling in the plan, including any postenrollment or employer-imposed waiting period.~~

1 ~~SEC. 2.~~

2 ~~SEC. 3.~~ Section 1357.506 of the Health and Safety Code is
3 repealed.

4 ~~SEC. 3.~~

5 ~~SEC. 4.~~ Section 1357.506 is added to the Health and Safety
6 Code, to read:

7 1357.506. A small employer health care service plan contract
8 shall not impose a preexisting condition provision or a waiting or
9 affiliation period upon any individual.

10 ~~SEC. 4.~~

11 ~~SEC. 5.~~ Section 1357.514 of the Health and Safety Code is
12 amended to read:

13 1357.514. In connection with the offering for sale of a small
14 employer health care service plan contract subject to this article,
15 each plan shall make a reasonable disclosure, as part of its
16 solicitation and sales materials, of the following:

17 (a) The provisions concerning the plan's right to change
18 premium rates and the factors other than provision of services
19 experience that affect changes in premium rates. The plan shall
20 disclose that claims experience cannot be used.

21 (b) Provisions relating to the guaranteed issue and renewal of
22 contracts.

23 (c) A statement that no preexisting condition provisions shall
24 be allowed.

25 (d) Provisions relating to the small employer's right to apply
26 for any small employer health care service plan contract written,
27 issued, or administered by the plan at the time of application for
28 a new health care service plan contract, or at the time of renewal
29 of a health care service plan contract, consistent with the
30 requirements of PPACA.

31 (e) The availability, upon request, of a listing of all the plan's
32 contracts and benefit plan designs offered, both inside and outside
33 the Exchange, to small employers, including the rates for each
34 contract.

35 (f) At the time it offers a contract to a small employer, each plan
36 shall provide the small employer with a statement of all of its small
37 employer health care service plan contracts, including the rates
38 for each plan contract, in the service area in which the employer's
39 employees and eligible dependents who are to be covered by the
40 plan contract work or reside. For purposes of this subdivision,

1 plans that are affiliated plans or that are eligible to file a
2 consolidated income tax return shall be treated as one health plan.

3 (g) Each plan shall do all of the following:

4 (1) Prepare a brochure that summarizes all of its plan contracts
5 offered to small employers and to make this summary available
6 to any small employer and to solicitors upon request. The summary
7 shall include for each contract information on benefits provided,
8 a generic description of the manner in which services are provided,
9 such as how access to providers is limited, benefit limitations,
10 required copayments and deductibles, and a phone number that
11 can be called for more detailed benefit information. Plans are
12 required to keep the information contained in the brochure accurate
13 and up to date and, upon updating the brochure, send copies to
14 solicitors and solicitor firms with whom the plan contracts to solicit
15 enrollments or subscriptions.

16 (2) For each contract, prepare a more detailed evidence of
17 coverage and make it available to small employers, solicitors, and
18 solicitor firms upon request. The evidence of coverage shall contain
19 all information that a prudent buyer would need to be aware of in
20 making contract selections.

21 (3) Provide copies of the current summary brochure to all
22 solicitors and solicitor firms contracting with the plan to solicit
23 enrollments or subscriptions from small employers.

24 For purposes of this subdivision, plans that are affiliated plans
25 or that are eligible to file a consolidated income tax return shall
26 be treated as one health plan.

27 (h) Every solicitor or solicitor firm contracting with one or more
28 plans to solicit enrollments or subscriptions from small employers
29 shall do all of the following:

30 (1) When providing information on contracts to a small
31 employer but making no specific recommendations on particular
32 plan contracts:

33 (A) Advise the small employer of the plan's obligation to sell
34 to any small employer any small employer health care service plan
35 contract, consistent with PPACA, and provide the small employer,
36 upon request, with the actual rates that would be charged to that
37 employer for a given contract.

38 (B) Notify the small employer that the solicitor or solicitor firm
39 will procure rate and benefit information for the small employer

1 on any plan contract offered by a plan whose contract the solicitor
2 sells.

3 (C) Notify the small employer that upon request the solicitor or
4 solicitor firm will provide the small employer with the summary
5 brochure required under paragraph (1) of subdivision (g) for any
6 plan contract offered by a plan with which the solicitor or solicitor
7 firm has contracted to solicit enrollments or subscriptions.

8 (D) Notify the small employer of the availability of coverage
9 and the availability of tax credits for certain employers consistent
10 with PPACA and state law, including any rules, regulations, or
11 guidance issued in connection therewith.

12 (2) When recommending a particular benefit plan design or
13 designs, advise the small employer that, upon request, the agent
14 will provide the small employer with the brochure required by
15 paragraph (1) of subdivision (g) containing the benefit plan design
16 or designs being recommended by the agent or broker.

17 (3) Prior to filing an application for a small employer for a
18 particular contract:

19 (A) For each of the plan contracts offered by the plan whose
20 contract the solicitor or solicitor firm is offering, provide the small
21 employer with the benefit summary required in paragraph (1) of
22 subdivision (g) and the premium for that particular employer.

23 (B) Notify the small employer that, upon request, the solicitor
24 or solicitor firm will provide the small employer with an evidence
25 of coverage brochure for each contract the plan offers.

26 (C) Obtain a signed statement from the small employer
27 acknowledging that the small employer has received the disclosures
28 required by this section.

29 ~~SEC. 5.~~

30 *SEC. 6.* Section 1357.600 of the Health and Safety Code is
31 amended to read:

32 1357.600. As used in this article, the following definitions shall
33 apply:

34 (a) "Dependent" means the spouse or registered domestic
35 partner, or child, of an eligible employee, subject to applicable
36 terms of the health care service plan contract covering the
37 employee, and includes dependents of guaranteed association
38 members if the association elects to include dependents under its
39 health coverage at the same time it determines its membership
40 composition pursuant to subdivision (n).

1 (b) “Eligible employee” means either of the following:

2 (1) Any permanent employee who is actively engaged on a
3 full-time basis in the conduct of the business of the small employer
4 with a normal workweek of an average of 30 hours per week over
5 the course of a month, at the small employer’s regular places of
6 business, who has met any statutorily authorized applicable waiting
7 period requirements. The term includes sole proprietors or partners
8 of a partnership, if they are actively engaged on a full-time basis
9 in the small employer’s business and included as employees under
10 a health care service plan contract of a small employer, but does
11 not include employees who work on a part-time, temporary, or
12 substitute basis. It includes any eligible employee, as defined in
13 this paragraph, who obtains coverage through a guaranteed
14 association. Employees of employers purchasing through a
15 guaranteed association shall be deemed to be eligible employees
16 if they would otherwise meet the definition except for the number
17 of persons employed by the employer. Permanent employees who
18 work at least 20 hours but not more than 29 hours are deemed to
19 be eligible employees if all four of the following apply:

20 (A) They otherwise meet the definition of an eligible employee
21 except for the number of hours worked.

22 (B) The employer offers the employees health coverage under
23 a health benefit plan.

24 (C) All similarly situated individuals are offered coverage under
25 the health benefit plan.

26 (D) The employee must have worked at least 20 hours per
27 normal workweek for at least 50 percent of the weeks in the
28 previous calendar quarter. The health care service plan may request
29 any necessary information to document the hours and time period
30 in question, including, but not limited to, payroll records and
31 employee wage and tax filings.

32 (2) Any member of a guaranteed association as defined in
33 subdivision (n).

34 (c) “In force business” means an existing health benefit plan
35 contract issued by the plan to a small employer.

36 (d) “Late enrollee” means an eligible employee or dependent
37 who has declined enrollment in a health benefit plan offered by a
38 small employer at the time of the initial enrollment period provided
39 under the terms of the health benefit plan and who subsequently
40 requests enrollment in a health benefit plan of that small employer,

1 provided that the initial enrollment period shall be a period of at
2 least 30 days. It also means any member of an association that is
3 a guaranteed association as well as any other person eligible to
4 purchase through the guaranteed association when that person has
5 failed to purchase coverage during the initial enrollment period
6 provided under the terms of the guaranteed association's plan
7 contract and who subsequently requests enrollment in the plan,
8 provided that the initial enrollment period shall be a period of at
9 least 30 days. However, an eligible employee, any other person
10 eligible for coverage through a guaranteed association pursuant to
11 subdivision (n), or an eligible dependent shall not be considered
12 a late enrollee if any of the following is applicable:

13 (1) The individual meets all of the following requirements:

14 (A) He or she was covered under another employer health
15 benefit plan, the Healthy Families Program, the Access for Infants
16 and Mothers (AIM) Program, the Medi-Cal program, or coverage
17 through the California Health Benefit Exchange at the time the
18 individual was eligible to enroll.

19 (B) He or she certified at the time of the initial enrollment that
20 coverage under another employer health benefit plan, the Healthy
21 Families Program, the AIM Program, the Medi-Cal program, or
22 coverage through the California Health Benefit Exchange was the
23 reason for declining enrollment, provided that, if the individual
24 was covered under another employer health benefit plan, including
25 a plan offered through the California Health Benefit Exchange,
26 the individual was given the opportunity to make the certification
27 required by this subdivision and was notified that failure to do so
28 could result in later treatment as a late enrollee.

29 (C) He or she has lost or will lose coverage under another
30 employer health benefit plan as a result of termination of
31 employment of the individual or of a person through whom the
32 individual was covered as a dependent, change in employment
33 status of the individual or of a person through whom the individual
34 was covered as a dependent, termination of the other plan's
35 coverage, cessation of an employer's contribution toward an
36 employee's or dependent's coverage, death of the person through
37 whom the individual was covered as a dependent, legal separation,
38 or divorce; or he or she has lost or will lose coverage under the
39 Healthy Families Program, the AIM Program, the Medi-Cal

1 program, or coverage through the California Health Benefit
2 Exchange.

3 (D) He or she requests enrollment within 30 days after
4 termination of coverage or employer contribution toward coverage
5 provided under another employer health benefit plan, or requests
6 enrollment within 60 days after termination of Medi-Cal program
7 coverage, AIM Program coverage, Healthy Families Program
8 coverage, or coverage through the California Health Benefit
9 Exchange.

10 (2) The employer offers multiple health benefit plans and the
11 employee elects a different plan during an open enrollment period.

12 (3) A court has ordered that coverage be provided for a spouse
13 or minor child under a covered employee's health benefit plan.

14 (4) (A) In the case of an eligible employee, as defined in
15 paragraph (1) of subdivision (b), the plan cannot produce a written
16 statement from the employer stating that the individual or the
17 person through whom the individual was eligible to be covered as
18 a dependent, prior to declining coverage, was provided with, and
19 signed, acknowledgment of an explicit written notice in boldface
20 type specifying that failure to elect coverage during the initial
21 enrollment period permits the plan to impose, at the time of the
22 individual's later decision to elect coverage, an exclusion from
23 coverage for no longer than 60 days, unless the individual meets
24 the criteria specified in paragraph (1), (2), or (3). This exclusion
25 from coverage shall not be considered a waiting period in violation
26 of Section 1357.51 or 1357.607.

27 (B) In the case of an association member who did not purchase
28 coverage through a guaranteed association, the plan cannot produce
29 a written statement from the association stating that the association
30 sent a written notice in boldface type to all potentially eligible
31 association members at their last known address prior to the initial
32 enrollment period informing members that failure to elect coverage
33 during the initial enrollment period permits the plan to impose, at
34 the time of the member's later decision to elect coverage, an
35 exclusion from coverage for no longer than 60 days, unless the
36 individual meets the requirements of subparagraphs (A), (C), and
37 (D) of paragraph (1) or meets the requirements of paragraph (2)
38 or (3). This exclusion from coverage shall not be considered a
39 waiting period in violation of Section 1357.51 or 1357.607.

1 (C) In the case of an employer or person who is not a member
2 of an association, was eligible to purchase coverage through a
3 guaranteed association, and did not do so, and would not be eligible
4 to purchase guaranteed coverage unless purchased through a
5 guaranteed association, the employer or person can demonstrate
6 that he or she meets the requirements of subparagraphs (A), (C),
7 and (D) of paragraph (1), or meets the requirements of paragraph
8 (2) or (3), or that he or she recently had a change in status that
9 would make him or her eligible and that application for enrollment
10 was made within 30 days of the change.

11 (5) The individual is an employee or dependent who meets the
12 criteria described in paragraph (1) and was under a COBRA
13 continuation provision and the coverage under that provision has
14 been exhausted. For purposes of this section, the definition of
15 “COBRA” set forth in subdivision (e) of Section 1373.621 shall
16 apply.

17 (6) The individual is a dependent of an enrolled eligible
18 employee who has lost or will lose his or her coverage under the
19 Healthy Families Program, the AIM Program, the Medi-Cal
20 program, or a health benefit plan offered through the California
21 Health Benefit Exchange and requests enrollment within 60 days
22 after termination of that coverage.

23 (7) The individual is an eligible employee who previously
24 declined coverage under an employer health benefit plan, including
25 a plan offered through the California Health Benefit Exchange,
26 and who has subsequently acquired a dependent who would be
27 eligible for coverage as a dependent of the employee through
28 marriage, birth, adoption, or placement for adoption, and who
29 enrolls for coverage under that employer health benefit plan on
30 his or her behalf and on behalf of his or her dependent within 30
31 days following the date of marriage, birth, adoption, or placement
32 for adoption, in which case the effective date of coverage shall be
33 the first day of the month following the date the completed request
34 for enrollment is received in the case of marriage, or the date of
35 birth, or the date of adoption or placement for adoption, whichever
36 applies. Notice of the special enrollment rights contained in this
37 paragraph shall be provided by the employer to an employee at or
38 before the time the employee is offered an opportunity to enroll
39 in plan coverage.

(8) The individual is an eligible employee who has declined coverage for himself or herself or his or her dependents during a previous enrollment period because his or her dependents were covered by another employer health benefit plan, including a plan offered through the California Health Benefit Exchange, at the time of the previous enrollment period. That individual may enroll himself or herself or his or her dependents for plan coverage during a special open enrollment opportunity if his or her dependents have lost or will lose coverage under that other employer health benefit plan. The special open enrollment opportunity shall be requested by the employee not more than 30 days after the date that the other health coverage is exhausted or terminated. Upon enrollment, coverage shall be effective not later than the first day of the first calendar month beginning after the date the request for enrollment is received. Notice of the special enrollment rights contained in this paragraph shall be provided by the employer to an employee at or before the time the employee is offered an opportunity to enroll in plan coverage.

(e) “Preexisting condition provision” means a contract provision that excludes coverage for charges or expenses incurred during a specified period following the enrollee’s effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. No health care service plan shall limit or exclude coverage for any individual based on a preexisting condition whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date.

(f) “Creditable coverage” means:

(1) Any individual or group policy, contract, or program that is written or administered by a disability insurer, health care service plan, fraternal benefits society, self-insured employer plan, or any other entity, in this state or elsewhere, and that arranges or provides medical, hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage but does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, insurance arising out of a workers’ compensation or similar law, automobile medical payment

1 insurance, or insurance under which benefits are payable with or
2 without regard to fault and that is statutorily required to be
3 contained in any liability insurance policy or equivalent
4 self-insurance.

5 (2) The Medicare Program pursuant to Title XVIII of the federal
6 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

7 (3) The Medicaid Program pursuant to Title XIX of the federal
8 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

9 (4) Any other publicly sponsored program, provided in this state
10 or elsewhere, of medical, hospital, and surgical care.

11 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
12 (Civilian Health and Medical Program of the Uniformed Services
13 (CHAMPUS)).

14 (6) A medical care program of the Indian Health Service or of
15 a tribal organization.

16 (7) A health plan offered under 5 U.S.C. Chapter 89
17 (commencing with Section 8901) (Federal Employees Health
18 Benefits Program (FEHBP)).

19 (8) A public health plan as defined in federal regulations
20 authorized by Section 2701(c)(1)(I) of the Public Health Service
21 Act, as amended by Public Law 104-191, the Health Insurance
22 Portability and Accountability Act of 1996.

23 (9) A health benefit plan under Section 5(e) of the Peace Corps
24 Act (22 U.S.C. Sec. 2504(e)).

25 (10) Any other creditable coverage as defined by subsection (c)
26 of Section 2704 of Title XXVII of the federal Public Health Service
27 Act (42 U.S.C. Sec. 300gg-3(c)).

28 (g) “Rating period” means the period for which premium rates
29 established by a plan are in effect and shall be no less than 12
30 months from the date of issuance or renewal of the health care
31 service plan contract.

32 (h) “Risk adjusted employee risk rate” means the rate determined
33 for an eligible employee of a small employer in a particular risk
34 category after applying the risk adjustment factor.

35 (i) “Risk adjustment factor” means the percentage adjustment
36 to be applied equally to each standard employee risk rate for a
37 particular small employer, based upon any expected deviations
38 from standard cost of services. This factor may not be more than
39 110 percent or less than 90 percent.

1 (j) “Risk category” means the following characteristics of an
2 eligible employee: age, geographic region, and family composition
3 of the employee, plus the health benefit plan selected by the small
4 employer.

5 (1) No more than the following age categories may be used in
6 determining premium rates:

7 Under 30

8 30–39

9 40–49

10 50–54

11 55–59

12 60–64

13 65 and over

14 However, for the 65 and over age category, separate premium
15 rates may be specified depending upon whether coverage under
16 the plan contract will be primary or secondary to benefits provided
17 by the Medicare Program pursuant to Title XVIII of the federal
18 Social Security Act (42 U.S.C. Sec. 1395 et seq.).

19 (2) Small employer health care service plans shall base rates to
20 small employers using no more than the following family size
21 categories:

22 (A) Single.

23 (B) Married couple or registered domestic partners.

24 (C) One adult and child or children.

25 (D) Married couple or registered domestic partners and child
26 or children.

27 (3) (A) In determining rates for small employers, a plan that
28 operates statewide shall use no more than nine geographic regions
29 in the state, have no region smaller than an area in which the first
30 three digits of all its ZIP Codes are in common within a county,
31 and divide no county into more than two regions. Plans shall be
32 deemed to be operating statewide if their coverage area includes
33 90 percent or more of the state’s population. Geographic regions
34 established pursuant to this section shall, as a group, cover the
35 entire state, and the area encompassed in a geographic region shall
36 be separate and distinct from areas encompassed in other
37 geographic regions. Geographic regions may be noncontiguous.

38 (B) (i) In determining rates for small employers, a plan that
39 does not operate statewide shall use no more than the number of
40 geographic regions in the state that is determined by the following

1 formula: the population, as determined in the last federal census,
2 of all counties that are included in their entirety in a plan's service
3 area divided by the total population of the state, as determined in
4 the last federal census, multiplied by nine. The resulting number
5 shall be rounded to the nearest whole integer. No region may be
6 smaller than an area in which the first three digits of all its ZIP
7 Codes are in common within a county and no county may be
8 divided into more than two regions. The area encompassed in a
9 geographic region shall be separate and distinct from areas
10 encompassed in other geographic regions. Geographic regions
11 may be noncontiguous. No plan shall have less than one geographic
12 area.

13 (ii) If the formula in clause (i) results in a plan that operates in
14 more than one county having only one geographic region, then the
15 formula in clause (i) shall not apply and the plan may have two
16 geographic regions, provided that no county is divided into more
17 than one region.

18 Nothing in this section shall be construed to require a plan to
19 establish a new service area or to offer health coverage on a
20 statewide basis, outside of the plan's existing service area.

21 (k) (1) "Small employer" means any of the following:

22 (A) For plan years commencing on or after January 1, 2014,
23 and on or before December 31, 2015, any person, firm, proprietary
24 or nonprofit corporation, partnership, public agency, or association
25 that is actively engaged in business or service, that, on at least 50
26 percent of its working days during the preceding calendar quarter
27 or preceding calendar year, employed at least one, but no more
28 than 50, eligible employees, the majority of whom were employed
29 within this state, that was not formed primarily for purposes of
30 buying health care service plan contracts, and in which a bona fide
31 employer-employee relationship exists. For plan years commencing
32 on or after January 1, 2016, any person, firm, proprietary or
33 nonprofit corporation, partnership, public agency, or association
34 that is actively engaged in business or service, that, on at least 50
35 percent of its working days during the preceding calendar quarter
36 or preceding calendar year, employed at least one, but no more
37 than 100, eligible employees, the majority of whom were employed
38 within this state, that was not formed primarily for purposes of
39 buying health care service plan contracts, and in which a bona fide
40 employer-employee relationship exists. In determining whether

1 to apply the calendar quarter or calendar year test, a health care
2 service plan shall use the test that ensures eligibility if only one
3 test would establish eligibility. In determining the number of
4 eligible employees, companies that are affiliated companies and
5 that are eligible to file a combined tax return for purposes of state
6 taxation shall be considered one employer. Subsequent to the
7 issuance of a health care service plan contract to a small employer
8 pursuant to this article, and for the purpose of determining
9 eligibility, the size of a small employer shall be determined
10 annually. Except as otherwise specifically provided in this article,
11 provisions of this article that apply to a small employer shall
12 continue to apply until the plan contract anniversary following the
13 date the employer no longer meets the requirements of this
14 definition. It includes any small employer as defined in this
15 subparagraph who purchases coverage through a guaranteed
16 association, and any employer purchasing coverage for employees
17 through a guaranteed association. This subparagraph shall be
18 implemented to the extent consistent with PPACA, except that the
19 minimum requirement of one employee shall be implemented only
20 to the extent required by PPACA.

21 (B) Any guaranteed association, as defined in subdivision (m),
22 that purchases health coverage for members of the association.

23 (2) For plan years commencing on or after January 1, 2014, the
24 definition of an employer, for purposes of determining whether
25 an employer with one employee shall include sole proprietors,
26 certain owners of “S” corporations, or other individuals, shall be
27 consistent with Section 1304 of PPACA.

28 (l) “Standard employee risk rate” means the rate applicable to
29 an eligible employee in a particular risk category in a small
30 employer group.

31 (m) “Guaranteed association” means a nonprofit organization
32 comprised of a group of individuals or employers who associate
33 based solely on participation in a specified profession or industry,
34 accepting for membership any individual or employer meeting its
35 membership criteria, and that (1) includes one or more small
36 employers as defined in subparagraph (A) of paragraph (1) of
37 subdivision (k), (2) does not condition membership directly or
38 indirectly on the health or claims history of any person, (3) uses
39 membership dues solely for and in consideration of the membership
40 and membership benefits, except that the amount of the dues shall

1 not depend on whether the member applies for or purchases
2 insurance offered to the association, (4) is organized and
3 maintained in good faith for purposes unrelated to insurance, (5)
4 has been in active existence on January 1, 1992, and for at least
5 five years prior to that date, (6) has included health insurance as
6 a membership benefit for at least five years prior to January 1,
7 1992, (7) has a constitution and bylaws, or other analogous
8 governing documents that provide for election of the governing
9 board of the association by its members, (8) offers any plan contract
10 that is purchased to all individual members and employer members
11 in this state, (9) includes any member choosing to enroll in the
12 plan contracts offered to the association provided that the member
13 has agreed to make the required premium payments, and (10)
14 covers at least 1,000 persons with the health care service plan with
15 which it contracts. The requirement of 1,000 persons may be met
16 if component chapters of a statewide association contracting
17 separately with the same carrier cover at least 1,000 persons in the
18 aggregate.

19 This subdivision applies regardless of whether a contract issued
20 by a plan is with an association, or a trust formed for or sponsored
21 by an association, to administer benefits for association members.

22 For purposes of this subdivision, an association formed by a
23 merger of two or more associations after January 1, 1992, and
24 otherwise meeting the criteria of this subdivision shall be deemed
25 to have been in active existence on January 1, 1992, if its
26 predecessor organizations had been in active existence on January
27 1, 1992, and for at least five years prior to that date and otherwise
28 met the criteria of this subdivision.

29 (n) "Members of a guaranteed association" means any individual
30 or employer meeting the association's membership criteria if that
31 person is a member of the association and chooses to purchase
32 health coverage through the association. At the association's
33 discretion, it also may include employees of association members,
34 association staff, retired members, retired employees of members,
35 and surviving spouses and dependents of deceased members.
36 However, if an association chooses to include these persons as
37 members of the guaranteed association, the association shall make
38 that election in advance of purchasing a plan contract. Health care
39 service plans may require an association to adhere to the
40 membership composition it selects for up to 12 months.

(o) “Affiliation period” means a period that, under the terms of the health care service plan contract, must expire before health care services under the contract become effective.

(p) “Grandfathered small employer health care service plan contract” means a small employer health care service plan contract that constitutes a grandfathered health plan.

(q) “Grandfathered health plan” has the meaning set forth in Section 1251 of PPACA.

(r) “Nongrandfathered small employer health care service plan contract” means a small employer health care service plan contract that is not a grandfathered health plan.

(s) “Plan year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

(t) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(u) “Registered domestic partner” means a person who has established a domestic partnership as described in Section 297 of the Family Code.

(v) “Small employer health care service plan contract” means a health care service plan contract issued to a small employer.

(w) “Waiting period” means a period that is required to pass with respect to an employee before the employee is eligible to be covered for benefits under the terms of the contract.

~~SEC. 6.~~

SEC. 7. Section 1357.607 of the Health and Safety Code is repealed.

~~SEC. 7.~~

SEC. 8. Section 1357.607 is added to the Health and Safety Code, to read:

1357.607. A small employer health care service plan contract shall not impose a preexisting condition provision or a waiting or affiliation period upon any individual.

~~SEC. 8.~~

SEC. 9. Section 1357.614 of the Health and Safety Code is amended to read:

1357.614. In connection with the renewal of a grandfathered small employer health care service plan contract, each plan shall

1 make a reasonable disclosure, as part of its solicitation and sales
2 materials, of the following:

3 (a) The extent to which premium rates for a specified small
4 employer are established or adjusted in part based upon the actual
5 or expected variation in service costs of the employees and
6 dependents of the small employer.

7 (b) The provisions concerning the plan's right to change
8 premium rates and the factors other than provision of services
9 experience that affect changes in premium rates.

10 (c) Provisions relating to the guaranteed issue and renewal of
11 contracts.

12 (d) Provisions relating to the effect of any waiting or affiliation
13 provision.

14 (e) Provisions relating to the small employer's right to apply
15 for any nongrandfathered small employer health care service plan
16 contract written, issued, or administered by the plan at the time of
17 application for a new health care service plan contract, or at the
18 time of renewal of a health care service plan contract, consistent
19 with the requirements of PPACA.

20 (f) The availability, upon request, of a listing of all the plan's
21 nongrandfathered small employer health care service plan contracts
22 and benefit plan designs offered, both inside and outside the
23 California Health Benefit Exchange, including the rates for each
24 contract.

25 (g) At the time it renews a grandfathered small employer health
26 care service plan contract, each plan shall provide the small
27 employer with a statement of all of its nongrandfathered small
28 employer health care service plan contracts, including the rates
29 for each plan contract, in the service area in which the employer's
30 employees and eligible dependents who are to be covered by the
31 plan contract work or reside. For purposes of this subdivision,
32 plans that are affiliated plans or that are eligible to file a
33 consolidated income tax return shall be treated as one health plan.

34 (h) Each plan shall do all of the following:

35 (1) Prepare a brochure that summarizes all of its small employer
36 health care service plan contracts and to make this summary
37 available to any small employer and to solicitors upon request.
38 The summary shall include for each contract information on
39 benefits provided, a generic description of the manner in which
40 services are provided, such as how access to providers is limited,

benefit limitations, required copayments and deductibles, standard employee risk rates, and a phone number that can be called for more detailed benefit information. Plans are required to keep the information contained in the brochure accurate and up to date and, upon updating the brochure, send copies to solicitors and solicitor firms with which the plan contracts to solicit enrollments or subscriptions.

(2) For each contract, prepare a more detailed evidence of coverage and make it available to small employers, solicitors, and solicitor firms upon request. The evidence of coverage shall contain all information that a prudent buyer would need to be aware of in making contract selections.

(3) Provide to small employers and solicitors, upon request, for any given small employer the sum of the standard employee risk rates and the sum of the risk adjusted employee risk rates. When requesting this information, small employers, solicitors, and solicitor firms shall provide the plan with the information the plan needs to determine the small employer's risk adjusted employee risk rate.

(4) Provide copies of the current summary brochure to all solicitors and solicitor firms contracting with the plan to solicit enrollments or subscriptions from small employers.

For purposes of this subdivision, plans that are affiliated plans or that are eligible to file a consolidated income tax return shall be treated as one health plan.

~~SEC. 9.~~

SEC. 10. Section 10198.7 of the Insurance Code is amended to read:

10198.7. (a) A health benefit plan for group coverage shall not impose any preexisting condition provision or waived condition provision upon any individual.

(b) (1) A nongrandfathered health benefit plan for individual coverage shall not impose any preexisting condition provision or waived condition provision upon any individual.

(2) A grandfathered health benefit plan for individual coverage shall not exclude coverage on the basis of a waived condition provision or preexisting condition provision for a period greater than 12 months following the individual's effective date of coverage, nor limit or exclude coverage for a specific insured by type of illness, treatment, medical condition, or accident, except

1 for satisfaction of a preexisting condition provision or waived
2 condition provision pursuant to this article. Waivered condition
3 provisions or preexisting condition provisions contained in
4 individual grandfathered health benefit plans may relate only to
5 conditions for which medical advice, diagnosis, care, or treatment,
6 including use of prescription drugs, was recommended or received
7 from a licensed health practitioner during the 12 months
8 immediately preceding the effective date of coverage.

9 (3) If Section 5000A of the Internal Revenue Code, as added
10 by Section 1501 of PPACA, is repealed or amended to no longer
11 apply to the individual market, as defined in Section 2791 of the
12 Public Health Service Act (42 U.S.C. Sec. 300gg-91), paragraph
13 (1) shall become inoperative 12 months after the date of that repeal
14 or amendment and thereafter paragraph (2) shall apply also to
15 nongrandfathered health benefit plans for individual coverage.

16 (4) *In determining whether a preexisting condition provision*
17 *or a waived condition provision applies to an individual under*
18 *this subdivision, a health benefit plan shall credit the time the*
19 *individual was covered under creditable coverage, provided that*
20 *the individual becomes eligible for coverage under the succeeding*
21 *health benefit plan within 62 days of termination of prior coverage*
22 *and applies for coverage under the succeeding plan within the*
23 *applicable enrollment period.*

24 (c) A health benefit plan for group or individual coverage shall
25 not impose a waiting period.

26 ~~(d) In determining whether a preexisting condition provision or~~
27 ~~a waived condition provision applies to a person, a health benefit~~
28 ~~plan shall credit the time the person was covered under creditable~~
29 ~~coverage, provided that the person becomes eligible for coverage~~
30 ~~under the succeeding health benefit plan within 62 days of~~
31 ~~termination of prior coverage and applies for coverage under the~~
32 ~~succeeding plan within the applicable enrollment period. A plan~~
33 ~~shall also credit any time that an eligible employee must wait~~
34 ~~before enrolling in the plan, including any postenrollment or~~
35 ~~employer-imposed waiting period.~~

36 ~~SEC. 10.~~

37 *SEC. 11.* Section 10753.05 of the Insurance Code is amended
38 to read:

39 10753.05. (a) No group or individual policy or contract or
40 certificate of group insurance or statement of group coverage

1 providing benefits to employees of small employers as defined in
2 this chapter shall be issued or delivered by a carrier subject to the
3 jurisdiction of the commissioner regardless of the situs of the
4 contract or master policyholder or of the domicile of the carrier
5 nor, except as otherwise provided in Sections 10270.91 and
6 10270.92, shall a carrier provide coverage subject to this chapter
7 until a copy of the form of the policy, contract, certificate, or
8 statement of coverage is filed with and approved by the
9 commissioner in accordance with Sections 10290 and 10291, and
10 the carrier has complied with the requirements of Section 10753.17.

11 (b) (1) On and after October 1, 2013, each carrier shall fairly
12 and affirmatively offer, market, and sell all of the carrier's health
13 benefit plans that are sold to, offered through, or sponsored by,
14 small employers or associations that include small employers for
15 plan years on or after January 1, 2014, to all small employers in
16 each geographic region in which the carrier makes coverage
17 available or provides benefits.

18 (2) A carrier that offers qualified health plans through the
19 Exchange shall be deemed to be in compliance with paragraph (1)
20 with respect to health benefit plans offered through the Exchange
21 in those geographic regions in which the carrier offers plans
22 through the Exchange.

23 (3) A carrier shall provide enrollment periods consistent with
24 PPACA and described in Section 155.725 of Title 45 of the Code
25 of Federal Regulations. Commencing January 1, 2014, a carrier
26 shall provide special enrollment periods consistent with the special
27 enrollment periods described in Section 10965.3, to the extent
28 permitted by PPACA, except for the triggering events identified
29 in paragraphs (d)(3) and (d)(6) of Section 155.420 of Title 45 of
30 the Code of Federal Regulations with respect to health benefit
31 plans offered through the Exchange.

32 (4) Nothing in this section shall be construed to require an
33 association, or a trust established and maintained by an association
34 to receive a master insurance policy issued by an admitted insurer
35 and to administer the benefits thereof solely for association
36 members, to offer, market or sell a benefit plan design to those
37 who are not members of the association. However, if the
38 association markets, offers or sells a benefit plan design to those
39 who are not members of the association it is subject to the
40 requirements of this section. This shall apply to an association that

1 otherwise meets the requirements of paragraph (8) formed by
2 merger of two or more associations after January 1, 1992, if the
3 predecessor organizations had been in active existence on January
4 1, 1992, and for at least five years prior to that date and met the
5 requirements of paragraph (5).

6 (5) A carrier which (A) effective January 1, 1992, and at least
7 20 years prior to that date, markets, offers, or sells benefit plan
8 designs only to all members of one association and (B) does not
9 market, offer or sell any other individual, selected group, or group
10 policy or contract providing medical, hospital and surgical benefits
11 shall not be required to market, offer, or sell to those who are not
12 members of the association. However, if the carrier markets, offers
13 or sells any benefit plan design or any other individual, selected
14 group, or group policy or contract providing medical, hospital and
15 surgical benefits to those who are not members of the association
16 it is subject to the requirements of this section.

17 (6) Each carrier that sells health benefit plans to members of
18 one association pursuant to paragraph (5) shall submit an annual
19 statement to the commissioner which states that the carrier is selling
20 health benefit plans pursuant to paragraph (5) and which, for the
21 one association, lists all the information required by paragraph (7).

22 (7) Each carrier that sells health benefit plans to members of
23 any association shall submit an annual statement to the
24 commissioner which lists each association to which the carrier
25 sells health benefit plans, the industry or profession which is served
26 by the association, the association's membership criteria, a list of
27 officers, the state in which the association is organized, and the
28 site of its principal office.

29 (8) For purposes of paragraphs (4) and (6), an association is a
30 nonprofit organization comprised of a group of individuals or
31 employers who associate based solely on participation in a
32 specified profession or industry, accepting for membership any
33 individual or small employer meeting its membership criteria,
34 which do not condition membership directly or indirectly on the
35 health or claims history of any person, which uses membership
36 dues solely for and in consideration of the membership and
37 membership benefits, except that the amount of the dues shall not
38 depend on whether the member applies for or purchases insurance
39 offered by the association, which is organized and maintained in
40 good faith for purposes unrelated to insurance, which has been in

1 active existence on January 1, 1992, and at least five years prior
2 to that date, which has a constitution and bylaws, or other
3 analogous governing documents which provide for election of the
4 governing board of the association by its members, which has
5 contracted with one or more carriers to offer one or more health
6 benefit plans to all individual members and small employer
7 members in this state. Health coverage through an association that
8 is not related to employment shall be considered individual
9 coverage pursuant to Section 144.102(c) of Title 45 of the Code
10 of Federal Regulations.

11 (c) On and after October 1, 2013, each carrier shall make
12 available to each small employer all health benefit plans that the
13 carrier offers or sells to small employers or to associations that
14 include small employers for plan years on or after January 1, 2014.
15 Notwithstanding subdivision (c) of Section 10753, for purposes
16 of this subdivision, companies that are affiliated companies or that
17 are eligible to file a consolidated income tax return shall be treated
18 as one carrier.

19 (d) Each carrier shall do all of the following:

20 (1) Prepare a brochure that summarizes all of its health benefit
21 plans and make this summary available to small employers, agents,
22 and brokers upon request. The summary shall include for each
23 plan information on benefits provided, a generic description of the
24 manner in which services are provided, such as how access to
25 providers is limited, benefit limitations, required copayments and
26 deductibles, and a telephone number that can be called for more
27 detailed benefit information. Carriers are required to keep the
28 information contained in the brochure accurate and up to date, and,
29 upon updating the brochure, send copies to agents and brokers
30 representing the carrier. Any entity that provides administrative
31 services only with regard to a health benefit plan written or issued
32 by another carrier shall not be required to prepare a summary
33 brochure which includes that benefit plan.

34 (2) For each health benefit plan, prepare a more detailed
35 evidence of coverage and make it available to small employers,
36 agents and brokers upon request. The evidence of coverage shall
37 contain all information that a prudent buyer would need to be aware
38 of in making selections of benefit plan designs. An entity that
39 provides administrative services only with regard to a health benefit

1 plan written or issued by another carrier shall not be required to
2 prepare an evidence of coverage for that health benefit plan.

3 (3) Provide copies of the current summary brochure to all agents
4 or brokers who represent the carrier and, upon updating the
5 brochure, send copies of the updated brochure to agents and brokers
6 representing the carrier for the purpose of selling health benefit
7 plans.

8 (4) Notwithstanding subdivision (c) of Section 10753, for
9 purposes of this subdivision, companies that are affiliated
10 companies or that are eligible to file a consolidated income tax
11 return shall be treated as one carrier.

12 (e) Every agent or broker representing one or more carriers for
13 the purpose of selling health benefit plans to small employers shall
14 do all of the following:

15 (1) When providing information on a health benefit plan to a
16 small employer but making no specific recommendations on
17 particular benefit plan designs:

18 (A) Advise the small employer of the carrier's obligation to sell
19 to any small employer any of the health benefit plans it offers to
20 small employers, consistent with PPACA, and provide them, upon
21 request, with the actual rates that would be charged to that
22 employer for a given health benefit plan.

23 (B) Notify the small employer that the agent or broker will
24 procure rate and benefit information for the small employer on
25 any health benefit plan offered by a carrier for whom the agent or
26 broker sells health benefit plans.

27 (C) Notify the small employer that, upon request, the agent or
28 broker will provide the small employer with the summary brochure
29 required in paragraph (1) of subdivision (d) for any benefit plan
30 design offered by a carrier whom the agent or broker represents.

31 (D) Notify the small employer of the availability of coverage
32 and the availability of tax credits for certain employers consistent
33 with PPACA and state law, including any rules, regulations, or
34 guidance issued in connection therewith.

35 (2) When recommending a particular benefit plan design or
36 designs, advise the small employer that, upon request, the agent
37 will provide the small employer with the brochure required by
38 paragraph (1) of subdivision (d) containing the benefit plan design
39 or designs being recommended by the agent or broker.

1 (3) Prior to filing an application for a small employer for a
2 particular health benefit plan:

3 (A) For each of the health benefit plans offered by the carrier
4 whose health benefit plan the agent or broker is presenting, provide
5 the small employer with the benefit summary required in paragraph
6 (1) of subdivision (d) and the premium for that particular employer.

7 (B) Notify the small employer that, upon request, the agent or
8 broker will provide the small employer with an evidence of
9 coverage brochure for each health benefit plan the carrier offers.

10 (C) Obtain a signed statement from the small employer
11 acknowledging that the small employer has received the disclosures
12 required by this paragraph and Section 10753.16.

13 (f) No carrier, agent, or broker shall induce or otherwise
14 encourage a small employer to separate or otherwise exclude an
15 eligible employee from a health benefit plan which, in the case of
16 an eligible employee meeting the definition in paragraph (1) of
17 subdivision (f) of Section 10753, is provided in connection with
18 the employee's employment or which, in the case of an eligible
19 employee as defined in paragraph (2) of subdivision (f) of Section
20 10753, is provided in connection with a guaranteed association.

21 (g) No carrier shall reject an application from a small employer
22 for a health benefit plan provided:

23 (1) The small employer as defined by subparagraph (A) of
24 paragraph (1) of subdivision (q) of Section 10753 offers health
25 benefits to 100 percent of its eligible employees as defined in
26 paragraph (1) of subdivision (f) of Section 10753. Employees who
27 waive coverage on the grounds that they have other group coverage
28 shall not be counted as eligible employees.

29 (2) The small employer agrees to make the required premium
30 payments.

31 (h) No carrier or agent or broker shall, directly or indirectly,
32 engage in the following activities:

33 (1) Encourage or direct small employers to refrain from filing
34 an application for coverage with a carrier because of the health
35 status, claims experience, industry, occupation, or geographic
36 location within the carrier's approved service area of the small
37 employer or the small employer's employees.

38 (2) Encourage or direct small employers to seek coverage from
39 another carrier because of the health status, claims experience,
40 industry, occupation, or geographic location within the carrier's

1 approved service area of the small employer or the small
2 employer's employees.

3 (3) Employ marketing practices or benefit designs that will have
4 the effect of discouraging the enrollment of individuals with
5 significant health needs or discriminate based on the individual's
6 race, color, national origin, present or predicted disability, age,
7 sex, gender identity, sexual orientation, expected length of life,
8 degree of medical dependency, quality of life, or other health
9 conditions.

10 This subdivision shall be enforced in the same manner as Section
11 790.03, including through Sections 790.035 and 790.05.

12 (i) No carrier shall, directly or indirectly, enter into any contract,
13 agreement, or arrangement with an agent or broker that provides
14 for or results in the compensation paid to an agent or broker for a
15 health benefit plan to be varied because of the health status, claims
16 experience, industry, occupation, or geographic location of the
17 small employer or the small employer's employees. This
18 subdivision shall not apply with respect to a compensation
19 arrangement that provides compensation to an agent or broker on
20 the basis of percentage of premium, provided that the percentage
21 shall not vary because of the health status, claims experience,
22 industry, occupation, or geographic area of the small employer.

23 (j) (1) A health benefit plan offered to a small employer, as
24 defined in Section 1304(b) of PPACA and in Section 10753, shall
25 not establish rules for eligibility, including continued eligibility,
26 of an individual, or dependent of an individual, to enroll under the
27 terms of the plan based on any of the following health status-related
28 factors:

29 (A) Health status.

30 (B) Medical condition, including physical and mental illnesses.

31 (C) Claims experience.

32 (D) Receipt of health care.

33 (E) Medical history.

34 (F) Genetic information.

35 (G) Evidence of insurability, including conditions arising out
36 of acts of domestic violence.

37 (H) Disability.

38 (I) Any other health status-related factor as determined by any
39 federal regulations, rules, or guidance issued pursuant to Section
40 2705 of the federal Public Health Service Act.

1 (2) Notwithstanding Section 10291.5, a carrier shall not require
2 an eligible employee or dependent to fill out a health assessment
3 or medical questionnaire prior to enrollment under a health benefit
4 plan. A carrier shall not acquire or request information that relates
5 to a health status-related factor from the applicant or his or her
6 dependent or any other source prior to enrollment of the individual.

7 (k) (1) A carrier shall consider as a single risk pool for rating
8 purposes in the small employer market the claims experience of
9 all insureds in all nongrandfathered small employer health benefit
10 plans offered by the carrier in this state, whether offered as health
11 care service plan contracts or health insurance policies, including
12 those insureds and enrollees who enroll in coverage through the
13 Exchange and insureds and enrollees covered by the carrier outside
14 of the Exchange.

15 (2) At least each calendar year, and no more frequently than
16 each calendar quarter, a carrier shall establish an index rate for the
17 small employer market in the state based on the total combined
18 claims costs for providing essential health benefits, as defined
19 pursuant to Section 1302 of PPACA and Section 10112.27, within
20 the single risk pool required under paragraph (1). The index rate
21 shall be adjusted on a marketwide basis based on the total expected
22 marketwide payments and charges under the risk adjustment and
23 reinsurance programs established for the state pursuant to Sections
24 1343 and 1341 of PPACA. The premium rate for all of the carrier's
25 nongrandfathered health benefit plans shall use the applicable
26 index rate, as adjusted for total expected marketwide payments
27 and charges under the risk adjustment and reinsurance programs
28 established for the state pursuant to Sections 1343 and 1341 of
29 PPACA, subject only to the adjustments permitted under paragraph
30 (3).

31 (3) A carrier may vary premium rates for a particular
32 nongrandfathered health benefit plan from its index rate based
33 only on the following actuarially justified plan-specific factors:

34 (A) The actuarial value and cost-sharing design of the health
35 benefit plan.

36 (B) The health benefit plan's provider network, delivery system
37 characteristics, and utilization management practices.

38 (C) The benefits provided under the health benefit plan that are
39 in addition to the essential health benefits, as defined pursuant to
40 Section 1302 of PPACA. These additional benefits shall be pooled

1 with similar benefits within the single risk pool required under
2 paragraph (1) and the claims experience from those benefits shall
3 be utilized to determine rate variations for health benefit plans that
4 offer those benefits in addition to essential health benefits.

5 (D) Administrative costs, excluding any user fees required by
6 the Exchange.

7 (E) With respect to catastrophic plans, as described in subsection
8 (e) of Section 1302 of PPACA, the expected impact of the specific
9 eligibility categories for those plans.

10 (f) If a carrier enters into a contract, agreement, or other
11 arrangement with a third-party administrator or other entity to
12 provide administrative, marketing, or other services related to the
13 offering of health benefit plans to small employers in this state,
14 the third-party administrator shall be subject to this chapter.

15 (m) (1) Except as provided in paragraph (2), this section shall
16 become inoperative if Section 2702 of the federal Public Health
17 Service Act (42 U.S.C. Sec. 300gg-1), as added by Section 1201
18 of PPACA, is repealed, in which case, 12 months after the repeal,
19 carriers subject to this section shall instead be governed by Section
20 10705 to the extent permitted by federal law, and all references in
21 this chapter to this section shall instead refer to Section 10705,
22 except for purposes of paragraph (2).

23 (2) Paragraph (3) of subdivision (b) of this section shall remain
24 operative as it relates to health benefit plans offered through the
25 Exchange.

26 ~~SEC. 11.~~

27 *SEC. 12.* Section 10753.08 of the Insurance Code is repealed.

28 ~~SEC. 12.~~

29 *SEC. 13.* Section 10753.08 is added to the Insurance Code, to
30 read:

31 10753.08. A health benefit plan shall not impose a preexisting
32 condition provision or a waiting or affiliation period upon any
33 individual.

34 ~~SEC. 13.~~

35 *SEC. 14.* Section 10755 of the Insurance Code is amended to
36 read:

37 10755. As used in this chapter, the following definitions shall
38 apply:

1 (a) “Agent or broker” means a person or entity licensed under
2 Chapter 5 (commencing with Section 1621) of Part 2 of Division
3 1.

4 (b) “Benefit plan design” means a specific health coverage
5 product issued by a carrier to small employers, to trustees of
6 associations that include small employers, or to individuals if the
7 coverage is offered through employment or sponsored by an
8 employer. It includes services covered and the levels of copayment
9 and deductibles, and it may include the professional providers who
10 are to provide those services and the sites where those services are
11 to be provided. A benefit plan design may also be an integrated
12 system for the financing and delivery of quality health care services
13 which has significant incentives for the covered individuals to use
14 the system.

15 (c) “Carrier” means any disability insurance company or any
16 other entity that writes, issues, or administers health benefit plans
17 that cover the employees of small employers, regardless of the
18 situs of the contract or master policyholder.

19 (d) “Dependent” means the spouse or registered domestic
20 partner, or child, of an eligible employee, subject to applicable
21 terms of the health benefit plan covering the employee, and
22 includes dependents of guaranteed association members if the
23 association elects to include dependents under its health coverage
24 at the same time it determines its membership composition pursuant
25 to subdivision (t).

26 (e) “Eligible employee” means either of the following:

27 (1) Any permanent employee who is actively engaged on a
28 full-time basis in the conduct of the business of the small employer
29 with a normal workweek of an average of 30 hours per week over
30 the course of a month, in the small employer’s regular place of
31 business, who has met any statutorily authorized applicable waiting
32 period requirements. The term includes sole proprietors or partners
33 of a partnership, if they are actively engaged on a full-time basis
34 in the small employer’s business, and they are included as
35 employees under a health benefit plan of a small employer, but
36 does not include employees who work on a part-time, temporary,
37 or substitute basis. It includes any eligible employee, as defined
38 in this paragraph, who obtains coverage through a guaranteed
39 association. Employees of employers purchasing through a
40 guaranteed association shall be deemed to be eligible employees

1 if they would otherwise meet the definition except for the number
2 of persons employed by the employer. A permanent employee
3 who works at least 20 hours but not more than 29 hours is deemed
4 to be an eligible employee if all four of the following apply:

5 (A) The employee otherwise meets the definition of an eligible
6 employee except for the number of hours worked.

7 (B) The employer offers the employee health coverage under a
8 health benefit plan.

9 (C) All similarly situated individuals are offered coverage under
10 the health benefit plan.

11 (D) The employee must have worked at least 20 hours per
12 normal workweek for at least 50 percent of the weeks in the
13 previous calendar quarter. The insurer may request any necessary
14 information to document the hours and time period in question,
15 including, but not limited to, payroll records and employee wage
16 and tax filings.

17 (2) Any member of a guaranteed association as defined in
18 subdivision (t).

19 (f) “Enrollee” means an eligible employee or dependent who
20 receives health coverage through the program from a participating
21 carrier.

22 (g) “Financially impaired” means, for the purposes of this
23 chapter, a carrier that, on or after the effective date of this chapter,
24 is not insolvent and is either:

25 (1) Deemed by the commissioner to be potentially unable to
26 fulfill its contractual obligations.

27 (2) Placed under an order of rehabilitation or conservation by
28 a court of competent jurisdiction.

29 (h) “Health benefit plan” means a policy or contract written or
30 administered by a carrier that arranges or provides health care
31 benefits for the covered eligible employees of a small employer
32 and their dependents. The term does not include accident only,
33 credit, disability income, coverage of Medicare services pursuant
34 to contracts with the United States government, Medicare
35 supplement, long-term care insurance, dental, vision, coverage
36 issued as a supplement to liability insurance, automobile medical
37 payment insurance, or insurance under which benefits are payable
38 with or without regard to fault and that is statutorily required to
39 be contained in any liability insurance policy or equivalent
40 self-insurance.

1 (i) “In force business” means an existing health benefit plan
2 issued by the carrier to a small employer.

3 (j) “Late enrollee” means an eligible employee or dependent
4 who has declined health coverage under a health benefit plan
5 offered by a small employer at the time of the initial enrollment
6 period provided under the terms of the health benefit plan and who
7 subsequently requests enrollment in a health benefit plan of that
8 small employer, provided that the initial enrollment period shall
9 be a period of at least 30 days. It also means any member of an
10 association that is a guaranteed association as well as any other
11 person eligible to purchase through the guaranteed association
12 when that person has failed to purchase coverage during the initial
13 enrollment period provided under the terms of the guaranteed
14 association’s health benefit plan and who subsequently requests
15 enrollment in the plan, provided that the initial enrollment period
16 shall be a period of at least 30 days. However, an eligible
17 employee, another person eligible for coverage through a
18 guaranteed association pursuant to subdivision (t), or an eligible
19 dependent shall not be considered a late enrollee if any of the
20 following is applicable:

21 (1) The individual meets all of the following requirements:

22 (A) He or she was covered under another employer health
23 benefit plan, the Healthy Families Program, the Access for Infants
24 and Mothers (AIM) Program, the Medi-Cal program, or coverage
25 through the California Health Benefit Exchange at the time the
26 individual was eligible to enroll.

27 (B) He or she certified at the time of the initial enrollment that
28 coverage under another employer health benefit plan, the Healthy
29 Families Program, the AIM Program, the Medi-Cal program, or
30 the California Health Benefit Exchange was the reason for
31 declining enrollment provided that, if the individual was covered
32 under another employer health plan, the individual was given the
33 opportunity to make the certification required by this subdivision
34 and was notified that failure to do so could result in later treatment
35 as a late enrollee.

36 (C) He or she has lost or will lose coverage under another
37 employer health benefit plan as a result of termination of
38 employment of the individual or of a person through whom the
39 individual was covered as a dependent, change in employment
40 status of the individual, or of a person through whom the individual

1 was covered as a dependent, the termination of the other plan's
2 coverage, cessation of an employer's contribution toward an
3 employee or dependent's coverage, death of the person through
4 whom the individual was covered as a dependent, legal separation,
5 or divorce; or he or she has lost or will lose coverage under the
6 Healthy Families Program, the AIM Program, the Medi-Cal
7 program, or the California Health Benefit Exchange.

8 (D) He or she requests enrollment within 30 days after
9 termination of coverage or employer contribution toward coverage
10 provided under another employer health benefit plan, or requests
11 enrollment within 60 days after termination of Medi-Cal program
12 coverage, AIM Program coverage, Healthy Families Program
13 coverage, or coverage offered through the California Health Benefit
14 Exchange.

15 (2) The individual is employed by an employer who offers
16 multiple health benefit plans and the individual elects a different
17 plan during an open enrollment period.

18 (3) A court has ordered that coverage be provided for a spouse
19 or minor child under a covered employee's health benefit plan.

20 (4) (A) In the case of an eligible employee as defined in
21 paragraph (1) of subdivision (e), the carrier cannot produce a
22 written statement from the employer stating that the individual or
23 the person through whom an individual was eligible to be covered
24 as a dependent, prior to declining coverage, was provided with,
25 and signed acknowledgment of, an explicit written notice in
26 boldface type specifying that failure to elect coverage during the
27 initial enrollment period permits the carrier to impose, at the time
28 of the individual's later decision to elect coverage, an exclusion
29 from coverage for a period of 12 months unless the individual
30 meets the criteria specified in paragraph (1), (2), or (3). This
31 exclusion from coverage shall not be considered a waiting period
32 in violation of Section 10198.7 or 10755.08.

33 (B) In the case of an eligible employee who is a guaranteed
34 association member, the plan cannot produce a written statement
35 from the guaranteed association stating that the association sent a
36 written notice in boldface type to all potentially eligible association
37 members at their last known address prior to the initial enrollment
38 period informing members that failure to elect coverage during
39 the initial enrollment period permits the plan to impose, at the time
40 of the member's later decision to elect coverage, an exclusion from

1 coverage for a period of 12 months unless the member can
2 demonstrate that he or she meets the requirements of subparagraphs
3 (A), (C), and (D) of paragraph (1) or meets the requirements of
4 paragraph (2) or (3). This exclusion from coverage shall not be
5 considered a waiting period in violation of Section 10198.7 or
6 10755.08.

7 (C) In the case of an employer or person who is not a member
8 of an association, was eligible to purchase coverage through a
9 guaranteed association, and did not do so, and would not be eligible
10 to purchase guaranteed coverage unless purchased through a
11 guaranteed association, the employer or person can demonstrate
12 that he or she meets the requirements of subparagraphs (A), (C),
13 and (D) of paragraph (1), or meets the requirements of paragraph
14 (2) or (3), or that he or she recently had a change in status that
15 would make him or her eligible and that application for coverage
16 was made within 30 days of the change.

17 (5) The individual is an employee or dependent who meets the
18 criteria described in paragraph (1) and was under a COBRA
19 continuation provision and the coverage under that provision has
20 been exhausted. For purposes of this section, the definition of
21 “COBRA” set forth in subdivision (e) of Section 10116.5 shall
22 apply.

23 (6) The individual is a dependent of an enrolled eligible
24 employee who has lost or will lose his or her coverage under the
25 Healthy Families Program, the AIM Program, the Medi-Cal
26 program, or the California Health Benefit Exchange and requests
27 enrollment within 60 days after termination of that coverage.

28 (7) The individual is an eligible employee who previously
29 declined coverage under an employer health benefit plan, including
30 a plan offered through the California Health Benefit Exchange,
31 and who has subsequently acquired a dependent who would be
32 eligible for coverage as a dependent of the employee through
33 marriage, birth, adoption, or placement for adoption, and who
34 enrolls for coverage under that employer health benefit plan on
35 his or her behalf and on behalf of his or her dependent within 30
36 days following the date of marriage, birth, adoption, or placement
37 for adoption, in which case the effective date of coverage shall be
38 the first day of the month following the date the completed request
39 for enrollment is received in the case of marriage, or the date of
40 birth, or the date of adoption or placement for adoption, whichever

1 applies. Notice of the special enrollment rights contained in this
2 paragraph shall be provided by the employer to an employee at or
3 before the time the employee is offered an opportunity to enroll
4 in plan coverage.

5 (8) The individual is an eligible employee who has declined
6 coverage for himself or herself or his or her dependents during a
7 previous enrollment period because his or her dependents were
8 covered by another employer health benefit plan, including a plan
9 offered through the California Health Benefit Exchange, at the
10 time of the previous enrollment period. That individual may enroll
11 himself or herself or his or her dependents for plan coverage during
12 a special open enrollment opportunity if his or her dependents have
13 lost or will lose coverage under that other employer health benefit
14 plan. The special open enrollment opportunity shall be requested
15 by the employee not more than 30 days after the date that the other
16 health coverage is exhausted or terminated. Upon enrollment,
17 coverage shall be effective not later than the first day of the first
18 calendar month beginning after the date the request for enrollment
19 is received. Notice of the special enrollment rights contained in
20 this paragraph shall be provided by the employer to an employee
21 at or before the time the employee is offered an opportunity to
22 enroll in plan coverage.

23 (k) “Preexisting condition provision” means a policy provision
24 that excludes coverage for charges or expenses incurred during a
25 specified period following the insured’s effective date of coverage,
26 as to a condition for which medical advice, diagnosis, care, or
27 treatment was recommended or received during a specified period
28 immediately preceding the effective date of coverage.

29 (l) “Creditable coverage” means:

30 (1) Any individual or group policy, contract, or program, that
31 is written or administered by a disability insurer, health care service
32 plan, fraternal benefits society, self-insured employer plan, or any
33 other entity, in this state or elsewhere, and that arranges or provides
34 medical, hospital, and surgical coverage not designed to supplement
35 other private or governmental plans. The term includes continuation
36 or conversion coverage but does not include accident only, credit,
37 coverage for onsite medical clinics, disability income, Medicare
38 supplement, long-term care, dental, vision, coverage issued as a
39 supplement to liability insurance, insurance arising out of a
40 workers’ compensation or similar law, automobile medical payment

1 insurance, or insurance under which benefits are payable with or
2 without regard to fault and that is statutorily required to be
3 contained in any liability insurance policy or equivalent
4 self-insurance.

5 (2) The federal Medicare Program pursuant to Title XVIII of
6 the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

7 (3) The Medicaid Program pursuant to Title XIX of the federal
8 Social Security Act (42 U.S.C. Sec. 1396 et seq.).

9 (4) Any other publicly sponsored program, provided in this state
10 or elsewhere, of medical, hospital, and surgical care.

11 (5) 10 U.S.C. Chapter 55 (commencing with Section 1071)
12 (Civilian Health and Medical Program of the Uniformed Services
13 (CHAMPUS)).

14 (6) A medical care program of the Indian Health Service or of
15 a tribal organization.

16 (7) A health plan offered under 5 U.S.C. Chapter 89
17 (commencing with Section 8901) (Federal Employees Health
18 Benefits Program (FEHBP)).

19 (8) A public health plan as defined in federal regulations
20 authorized by Section 2701(c)(1)(I) of the federal Public Health
21 Service Act, as amended by Public Law 104-191, the federal Health
22 Insurance Portability and Accountability Act of 1996.

23 (9) A health benefit plan under Section 5(e) of the federal Peace
24 Corps Act (22 U.S.C. Sec. 2504(e)).

25 (10) Any other creditable coverage as defined by subdivision
26 (c) of Section 2704 of Title XXVII of the federal Public Health
27 Service Act (42 U.S.C. Sec. 300gg-3(c)).

28 (m) “Rating period” means the period for which premium rates
29 established by a carrier are in effect and shall be no less than 12
30 months from the date of issuance or renewal of the health benefit
31 plan.

32 (n) “Risk adjusted employee risk rate” means the rate determined
33 for an eligible employee of a small employer in a particular risk
34 category after applying the risk adjustment factor.

35 (o) “Risk adjustment factor” means the percent adjustment to
36 be applied equally to each standard employee risk rate for a
37 particular small employer, based upon any expected deviations
38 from standard claims. This factor may not be more than 110 percent
39 or less than 90 percent.

(p) “Risk category” means the following characteristics of an eligible employee: age, geographic region, and family size of the employee, plus the benefit plan design selected by the small employer.

(1) No more than the following age categories may be used in determining premium rates:

Under 30

30–39

40–49

50–54

55–59

60–64

65 and over

However, for the 65 and over age category, separate premium rates may be specified depending upon whether coverage under the health benefit plan will be primary or secondary to benefits provided by the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act.

(2) Small employer carriers shall base rates to small employers using no more than the following family size categories:

(A) Single.

(B) Married couple or registered domestic partners.

(C) One adult and child or children.

(D) Married couple or registered domestic partners and child or children.

(3) (A) In determining rates for small employers, a carrier that operates statewide shall use no more than nine geographic regions in the state, have no region smaller than an area in which the first three digits of all its ZIP Codes are in common within a county, and shall divide no county into more than two regions. Carriers shall be deemed to be operating statewide if their coverage area includes 90 percent or more of the state’s population. Geographic regions established pursuant to this section shall, as a group, cover the entire state, and the area encompassed in a geographic region shall be separate and distinct from areas encompassed in other geographic regions. Geographic regions may be noncontiguous.

(B) In determining rates for small employers, a carrier that does not operate statewide shall use no more than the number of geographic regions in the state than is determined by the following formula: the population, as determined in the last federal census,

1 of all counties which are included in their entirety in a carrier's
2 service area divided by the total population of the state, as
3 determined in the last federal census, multiplied by nine. The
4 resulting number shall be rounded to the nearest whole integer.
5 No region may be smaller than an area in which the first three
6 digits of all its ZIP Codes are in common within a county and no
7 county may be divided into more than two regions. The area
8 encompassed in a geographic region shall be separate and distinct
9 from areas encompassed in other geographic regions. Geographic
10 regions may be noncontiguous. No carrier shall have less than one
11 geographic area.

12 (q) (1) "Small employer" means either of the following:

13 (A) For plan years commencing on or after January 1, 2014,
14 and on or before December 31, 2015, any person, firm, proprietary
15 or nonprofit corporation, partnership, public agency, or association
16 that is actively engaged in business or service, that, on at least 50
17 percent of its working days during the preceding calendar quarter
18 or preceding calendar year, employed at least one, but no more
19 than 50, eligible employees, the majority of whom were employed
20 within this state, that was not formed primarily for purposes of
21 buying health benefit plans, and in which a bona fide
22 employer-employee relationship exists. For plan years commencing
23 on or after January 1, 2016, any person, firm, proprietary or
24 nonprofit corporation, partnership, public agency, or association
25 that is actively engaged in business or service, that, on at least 50
26 percent of its working days during the preceding calendar quarter
27 or preceding calendar year, employed at least one, but no more
28 than 100, eligible employees, the majority of whom were employed
29 within this state, that was not formed primarily for purposes of
30 buying health benefit plans, and in which a bona fide
31 employer-employee relationship exists. In determining whether
32 to apply the calendar quarter or calendar year test, a carrier shall
33 use the test that ensures eligibility if only one test would establish
34 eligibility. In determining the number of eligible employees,
35 companies that are affiliated companies and that are eligible to file
36 a combined tax return for purposes of state taxation shall be
37 considered one employer. Subsequent to the issuance of a health
38 benefit plan to a small employer pursuant to this chapter, and for
39 the purpose of determining eligibility, the size of a small employer
40 shall be determined annually. Except as otherwise specifically

1 provided in this chapter, provisions of this chapter that apply to a
2 small employer shall continue to apply until the plan contract
3 anniversary following the date the employer no longer meets the
4 requirements of this definition. It includes any small employer as
5 defined in this subparagraph who purchases coverage through a
6 guaranteed association, and any employer purchasing coverage
7 for employees through a guaranteed association. This subparagraph
8 shall be implemented to the extent consistent with PPACA, except
9 that the minimum requirement of one employee shall be
10 implemented only to the extent required by PPACA.

11 (B) Any guaranteed association, as defined in subdivision (s),
12 that purchases health coverage for members of the association.

13 (2) For plan years commencing on or after January 1, 2014, the
14 definition of an employer, for purposes of determining whether
15 an employer with one employee shall include sole proprietors,
16 certain owners of “S” corporations, or other individuals, shall be
17 consistent with Section 1304 of PPACA.

18 (r) “Standard employee risk rate” means the rate applicable to
19 an eligible employee in a particular risk category in a small
20 employer group.

21 (s) “Guaranteed association” means a nonprofit organization
22 comprised of a group of individuals or employers who associate
23 based solely on participation in a specified profession or industry,
24 accepting for membership any individual or employer meeting its
25 membership criteria which (1) includes one or more small
26 employers as defined in subparagraph (A) of paragraph (1) of
27 subdivision (q), (2) does not condition membership directly or
28 indirectly on the health or claims history of any person, (3) uses
29 membership dues solely for and in consideration of the membership
30 and membership benefits, except that the amount of the dues shall
31 not depend on whether the member applies for or purchases
32 insurance offered by the association, (4) is organized and
33 maintained in good faith for purposes unrelated to insurance, (5)
34 has been in active existence on January 1, 1992, and for at least
35 five years prior to that date, (6) has been offering health insurance
36 to its members for at least five years prior to January 1, 1992, (7)
37 has a constitution and bylaws, or other analogous governing
38 documents that provide for election of the governing board of the
39 association by its members, (8) offers any benefit plan design that
40 is purchased to all individual members and employer members in

1 this state, (9) includes any member choosing to enroll in the benefit
2 plan design offered to the association provided that the member
3 has agreed to make the required premium payments, and (10)
4 covers at least 1,000 persons with the carrier with which it
5 contracts. The requirement of 1,000 persons may be met if
6 component chapters of a statewide association contracting
7 separately with the same carrier cover at least 1,000 persons in the
8 aggregate.

9 This subdivision applies regardless of whether a master policy
10 by an admitted insurer is delivered directly to the association or a
11 trust formed for or sponsored by an association to administer
12 benefits for association members.

13 For purposes of this subdivision, an association formed by a
14 merger of two or more associations after January 1, 1992, and
15 otherwise meeting the criteria of this subdivision shall be deemed
16 to have been in active existence on January 1, 1992, if its
17 predecessor organizations had been in active existence on January
18 1, 1992, and for at least five years prior to that date and otherwise
19 met the criteria of this subdivision.

20 (t) “Members of a guaranteed association” means any individual
21 or employer meeting the association’s membership criteria if that
22 person is a member of the association and chooses to purchase
23 health coverage through the association. At the association’s
24 discretion, it may also include employees of association members,
25 association staff, retired members, retired employees of members,
26 and surviving spouses and dependents of deceased members.
27 However, if an association chooses to include those persons as
28 members of the guaranteed association, the association must so
29 elect in advance of purchasing coverage from a plan. Health plans
30 may require an association to adhere to the membership
31 composition it selects for up to 12 months.

32 (u) “Grandfathered health benefit plan” means a health benefit
33 plan that constitutes a grandfathered health plan.

34 (v) “Grandfathered health plan” has the meaning set forth in
35 Section 1251 of PPACA.

36 (w) “Nongrandfathered health benefit plan” means a health
37 benefit plan that is not a grandfathered health plan.

38 (x) “Plan year” has the meaning set forth in Section 144.103 of
39 Title 45 of the Code of Federal Regulations.

(y) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(z) “Waiting period” means a period that is required to pass with respect to the employee before the employee is eligible to be covered for benefits under the terms of the contract.

(aa) “Registered domestic partner” means a person who has established a domestic partnership as described in Section 297 of the Family Code.

~~SEC. 14.~~

SEC. 15. Section 10755.05 of the Insurance Code is amended to read:

10755.05. (a) (1) Each carrier, except a self-funded employer, shall fairly and affirmatively renew all of the carrier’s health benefit plans that are sold to small employers or associations that include small employers.

(2) Nothing in this section shall be construed to require an association, or a trust established and maintained by an association to receive a master insurance policy issued by an admitted insurer and to administer the benefits thereof solely for association members, to offer, market or sell a benefit plan design to those who are not members of the association. However, if the association markets, offers or sells a benefit plan design to those who are not members of the association it is subject to the requirements of this section. This shall apply to an association that otherwise meets the requirements of paragraph (6) formed by merger of two or more associations after January 1, 1992, if the predecessor organizations had been in active existence on January 1, 1992, and for at least five years prior to that date and met the requirements of paragraph (3).

(3) A carrier which (A) effective January 1, 1992, and at least 20 years prior to that date, markets, offers, or sells benefit plan designs only to all members of one association and (B) does not market, offer or sell any other individual, selected group, or group policy or contract providing medical, hospital and surgical benefits shall not be required to market, offer, or sell to those who are not members of the association. However, if the carrier markets, offers or sells any benefit plan design or any other individual, selected

1 group, or group policy or contract providing medical, hospital and
2 surgical benefits to those who are not members of the association
3 it is subject to the requirements of this section.

4 (4) Each carrier that sells health benefit plans to members of
5 one association pursuant to paragraph (3) shall submit an annual
6 statement to the commissioner which states that the carrier is selling
7 health benefit plans pursuant to paragraph (3) and which, for the
8 one association, lists all the information required by paragraph (5).

9 (5) Each carrier that sells health benefit plans to members of
10 any association shall submit an annual statement to the
11 commissioner which lists each association to which the carrier
12 sells health benefit plans, the industry or profession which is served
13 by the association, the association's membership criteria, a list of
14 officers, the state in which the association is organized, and the
15 site of its principal office.

16 (6) For purposes of paragraphs (2) and (3), an association is a
17 nonprofit organization comprised of a group of individuals or
18 employers who associate based solely on participation in a
19 specified profession or industry, accepting for membership any
20 individual or small employer meeting its membership criteria,
21 which do not condition membership directly or indirectly on the
22 health or claims history of any person, which uses membership
23 dues solely for and in consideration of the membership and
24 membership benefits, except that the amount of the dues shall not
25 depend on whether the member applies for or purchases insurance
26 offered by the association, which is organized and maintained in
27 good faith for purposes unrelated to insurance, which has been in
28 active existence on January 1, 1992, and at least five years prior
29 to that date, which has a constitution and bylaws, or other
30 analogous governing documents which provide for election of the
31 governing board of the association by its members, which has
32 contracted with one or more carriers to offer one or more health
33 benefit plans to all individual members and small employer
34 members in this state.

35 (b) Each carrier shall make available to each small employer
36 all nongrandfathered health benefit plans that the carrier offers or
37 sells to small employers or to associations that include small
38 employers. Notwithstanding subdivision (c) of Section 10755, for
39 purposes of this subdivision, companies that are affiliated

1 companies or that are eligible to file a consolidated income tax
2 return shall be treated as one carrier.

3 (c) Each carrier shall do all of the following:

4 (1) Prepare a brochure that summarizes all of its health benefit
5 plans and make this summary available to small employers, agents,
6 and brokers upon request. The summary shall include for each
7 health benefit plan information on benefits provided, a generic
8 description of the manner in which services are provided, such as
9 how access to providers is limited, benefit limitations, required
10 copayments and deductibles, standard employee risk rates, and a
11 telephone number that can be called for more detailed benefit
12 information. Carriers are required to keep the information contained
13 in the brochure accurate and up to date, and, upon updating the
14 brochure, send copies to agents and brokers representing the carrier.
15 Any entity that provides administrative services only with regard
16 to a benefit plan design written or issued by another carrier shall
17 not be required to prepare a summary brochure which includes
18 that benefit plan design.

19 (2) For each health benefit plan, prepare a more detailed
20 evidence of coverage and make it available to small employers,
21 agents and brokers upon request. The evidence of coverage shall
22 contain all information that a prudent buyer would need to be aware
23 of in making selections of benefit plan designs. An entity that
24 provides administrative services only with regard to a benefit plan
25 design written or issued by another carrier shall not be required to
26 prepare an evidence of coverage for that benefit plan design.

27 (3) Provide to small employers and agents and brokers, upon
28 request, for any given small employer the sum of the standard
29 employee risk rates and the sum of the risk adjusted employee risk
30 rates. When requesting this information, small employers and
31 agents and brokers shall provide the plan with the information the
32 plan needs to determine the small employer's risk adjusted
33 employee risk rate.

34 (4) Provide copies of the current summary brochure to all agents
35 or brokers who represent the carrier and, upon updating the
36 brochure, send copies of the updated brochure to agents and brokers
37 representing the carrier for the purpose of selling health benefit
38 plans.

39 (5) Notwithstanding subdivision (c) of Section 10755, for
40 purposes of this subdivision, companies that are affiliated

1 companies or that are eligible to file a consolidated income tax
2 return shall be treated as one carrier.

3 (d) No carrier, agent, or broker shall induce or otherwise
4 encourage a small employer to separate or otherwise exclude an
5 eligible employee from a health benefit plan which, in the case of
6 an eligible employee meeting the definition in paragraph (1) of
7 subdivision (e) of Section 10755, is provided in connection with
8 the employee's employment or which, in the case of an eligible
9 employee as defined in paragraph (2) of subdivision (e) of Section
10 10755, is provided in connection with a guaranteed association.

11 (e) No carrier or agent or broker shall, directly or indirectly,
12 engage in the following activities:

13 (1) Encourage or direct small employers to refrain from filing
14 an application for coverage with a carrier because of the health
15 status, claims experience, industry, occupation, or geographic
16 location within the carrier's approved service area of the small
17 employer or the small employer's employees.

18 (2) Encourage or direct small employers to seek coverage from
19 another carrier or the California Health Benefit Exchange because
20 of the health status, claims experience, industry, occupation, or
21 geographic location within the carrier's approved service area of
22 the small employer or the small employer's employees.

23 (f) No carrier shall, directly or indirectly, enter into any contract,
24 agreement, or arrangement with an agent or broker that provides
25 for or results in the compensation paid to an agent or broker for a
26 health benefit plan to be varied because of the health status, claims
27 experience, industry, occupation, or geographic location of the
28 small employer or the small employer's employees. This
29 subdivision shall not apply with respect to a compensation
30 arrangement that provides compensation to an agent or broker on
31 the basis of percentage of premium, provided that the percentage
32 shall not vary because of the health status, claims experience,
33 industry, occupation, or geographic area of the small employer.

34 (g) A policy or contract that covers a small employer, as defined
35 in Section 1304(b) of PPACA and in subdivision (q) of Section
36 10755 shall not establish rules for eligibility, including continued
37 eligibility, of an individual, or dependent of an individual, to enroll
38 under the terms of the plan based on any of the following health
39 status-related factors:

40 (1) Health status.

- 1 (2) Medical condition, including physical and mental illnesses.
2 (3) Claims experience.
3 (4) Receipt of health care.
4 (5) Medical history.
5 (6) Genetic information.
6 (7) Evidence of insurability, including conditions arising out of
7 acts of domestic violence.
8 (8) Disability.
9 (9) Any other health status-related factor as determined by any
10 federal regulations, rules, or guidance issued pursuant to Section
11 2705 of the federal Public Health Service Act.

12 (h) If a carrier enters into a contract, agreement, or other
13 arrangement with a third-party administrator or other entity to
14 provide administrative, marketing, or other services related to the
15 offering of health benefit plans to small employers in this state,
16 the third-party administrator shall be subject to this chapter.

17 ~~SEC. 15.~~

18 *SEC. 16.* Section 10755.08 of the Insurance Code is repealed.

19 ~~SEC. 16.~~

20 *SEC. 17.* Section 10755.08 is added to the Insurance Code, to
21 read:

22 10755.08. A health benefit plan shall not impose a preexisting
23 condition provision or a waiting or affiliation period upon any
24 individual.

25 ~~SEC. 17.~~

26 *SEC. 18.* No reimbursement is required by this act pursuant to
27 Section 6 of Article XIII B of the California Constitution because
28 the only costs that may be incurred by a local agency or school
29 district will be incurred because this act creates a new crime or
30 infraction, eliminates a crime or infraction, or changes the penalty
31 for a crime or infraction, within the meaning of Section 17556 of
32 the Government Code, or changes the definition of a crime within
33 the meaning of Section 6 of Article XIII B of the California
34 Constitution.